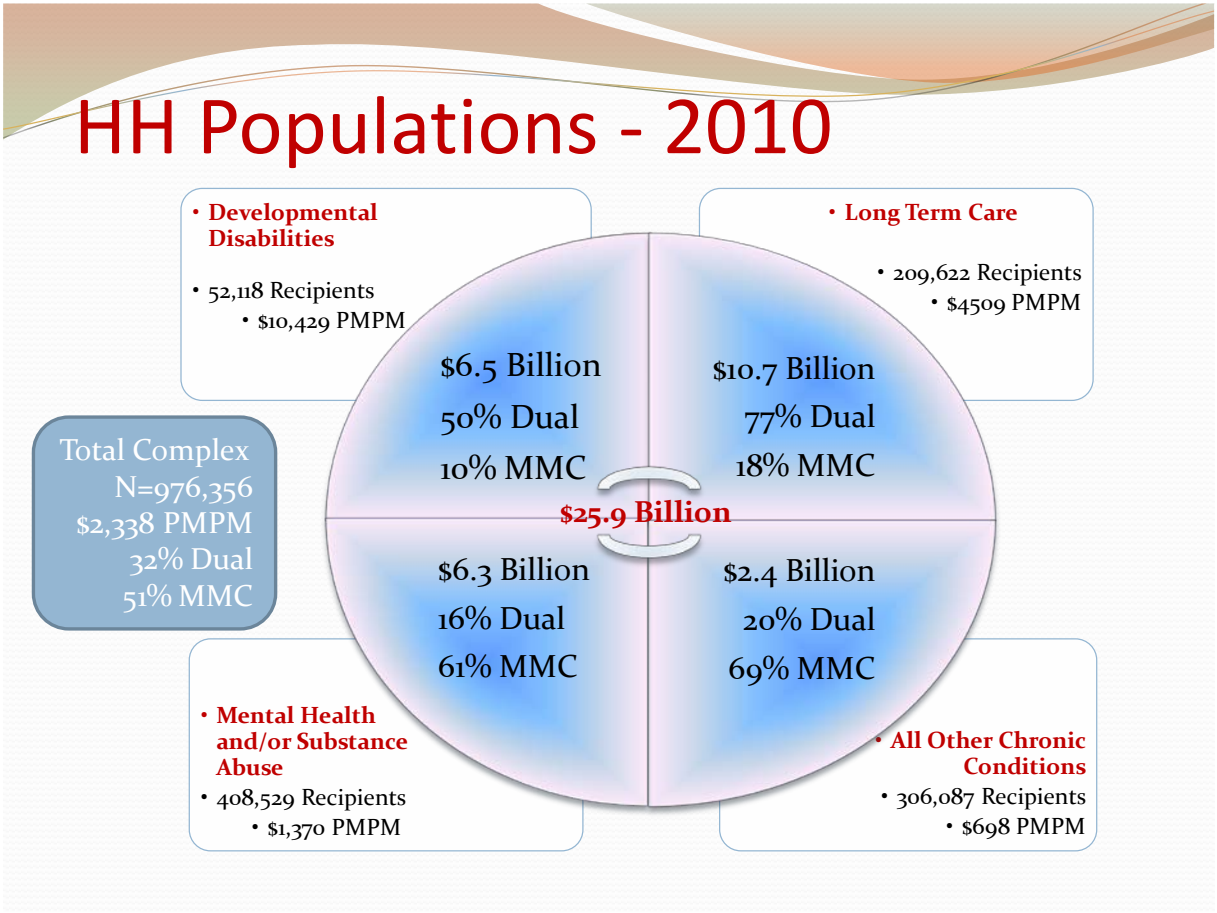
Preliminary NYS Health Home Rollout Plan

The State has organized the Health home population into four mutually exclusive categories of illness/disability. This model allows the State to tailor a health home care management approach taking into account the unique service delivery structures that each of these patient groups is currently receiving their care from. The overarching goal is to build care management that is a close to patient service delivery as possible.

Below is a graphic on these four populations will some Medicaid data on each:



Overall Rollout plan

The **first wave** of health home implementation will include the bottom two quadrants Mental Health/Substance abuse and the Other Chronic medical. The detailed roll out information for those two groups is included below.

In the **second wave** of health home implementation the Long Term Care population is targeted. The long term care health home approach includes two potential components both of which are still under development. The first component is to build a health home from within the existing managed long term care plan (MLTCP) structure and leverage and improve the existing care management that exists inside of that program. The other long term care component would include building care management networks of nursing homes and non-institutional providers to manage services (potentially both Medicaid and Medicare services). Both of these long term care components are the subject of ongoing discussions between State staff and CMS and the Innovations Center on how best to implement a health home for these populations. The MLTCP model could be implemented rather quickly.

In the **third wave** of health home implementation the developmentally disabled population is targeted. The development disabilities population is currently served in an existing targeted care management (TCM) program which will likely convert to health home after work is more completed on a very large Medicaid waiver that is being developed for this population.

Table 1: Preliminary snapshot of the State's overall HH role out plan:

Population	Preliminary Start Date for HH	Potential Members to Enroll (High and Mid Cost) *
Mental Health/Substance Abuse	Adults January 2012 (children later)	191,000
Other Chronic Medical	Adults January 2012 (children later)	143,000
Long Term Care	Spring 2012	98,000
Developmental Disabilities	Fall 2012	24,500
Total		**456,500**

* (Actual numbers will be based on capacity and further assessment of need for HH services – assumes 47 percent of each pop is high to mid cost – based on Analysis of MH/SA and Other Chronic Group expenditure – analysis is being refined for each population)

Health Home First Wave – Mental Health/Substance Abuse/Other Chronic Medical

The **first wave** of Health Home enrollment targeted to the Mental Health/Substance Abuse and Other Chronic medical groups in NYS will be done in **three phases** by county of recipient residence.

Table 2: Wave One Health Home Rollout by SFY and FFY - Mental Health/Substance Abuse/Chronic Medical Cohort

Health Home Enrollment Phasing			Phase	Tier									Total
			Phase 1			Phase 2			Phase 3				
State Fiscal Year	State Quarter	FFY & Qrt	High Cost	Mid Cost	Low Cost	High Cost	Mid Cost	Low Cost	High Cost	Mid Cost	Low Cost	
SFY '11-'12	Qrt 1	FFY '10-'11 Qrt 3	-	-	-	-	-	-	-	-	-	-
	Qrt 2	FFY '10-'11 Qrt 4	-	-	-	-	-	-	-	-	-	-
	Qrt 3	FFY '11-'12 Qrt 1	-	-	-	-	-	-	-	-	-	-
	Qrt 4	FFY '11-'12 Qrt 2	3,715	10,661	16,401	-	-	-	-	-	-	30,778
SFY '11-'12 Total			**3,715**	**10,661**	**16,401**	**-**	**-**	**-**	**-**	**-**	**-**	**30,778**
SFY '12-'13	Qrt 1	FFY '11-'12 Qrt 3	9,289	26,652	41,003	3,663	10,510	16,168	-	-	-	107,285
	Qrt 2	FFY '11-'12 Qrt 4	-	-	-	9,157	26,274	40,421	807	2,314	3,560	82,533
	Qrt 3	FFY '12-'13 Qrt 1	5,573	15,991	24,602	-	-	-	2,016	5,785	8,901	62,869
	Qrt 4	FFY '12-'13 Qrt 2	3,715	10,661	16,401	5,494	15,764	24,253	-	-	-	76,289
SFY '12-'13 Total			**18,577**	**53,305**	**82,007**	**18,313**	**52,548**	**80,842**	**2,823**	**8,100**	**12,461**	**328,976**
SFY '13-'14	Qrt 1	FFY '12-'13 Qrt 3	1,858	5,330	8,201	3,663	10,510	16,168	1,210	3,471	5,340	55,751
	Qrt 2	FFY '12-'13 Qrt 4	-	-	-	1,831	5,255	8,084	807	2,314	3,560	21,851
	Qrt 3	FFY '13-'14 Qrt 1	1,858	5,330	8,201	-	-	-	403	1,157	1,780	18,729
	Qrt 4	FFY '13-'14 Qrt 2	1,858	5,330	8,201	1,831	5,255	8,084	-	-	-	30,559
SFY '13-'14 Total			**5,573**	**15,991**	**24,602**	**7,325**	**21,019**	**32,337**	**2,420**	**6,943**	**10,681**	**126,891**
SFY '14-'15	Qrt 1	FFY '13-'14 Qrt 3	-	-	-	1,831	5,255	8,084	403	1,157	1,780	18,511
	Qrt 2	FFY '13-'14 Qrt 4	-	-	-	-	-	-	403	1,157	1,780	3,340
	Qrt 3	FFY '14-'15 Qrt 1	-	-	-	-	-	-	-	-	-	-
	Qrt 4	FFY '14-'15 Qrt 2	-	-	-	-	-	-	-	-	-	-
SFY '14-'15 Total			**-**	**-**	**-**	**1,831**	**5,255**	**8,084**	**807**	**2,314**	**3,560**	**21,851**
Total			**27,866**	**79,957**	**123,010**	**27,470**	**78,822**	**121,263**	**6,049**	**17,356**	**26,702**	**508,496**

* Low Cost Members are not slated for health home enrollment under the current plan but this could change as the project progresses and as high and mid cost members are assigned in a given region.

Wave One HH Member Assignment Algorithm

Eligible health home members will be assigned directly to approved HH networks by the State and will be assigned through health plans for members enrolled in Medicaid Managed Care. Initial assignment to State approved Health Home providers will be based on:

1. Higher Predictive Risk for Negative Event (Inpatient, Nursing Home, Death)
2. Lower or no Ambulatory Care Connectivity
3. Provider Loyalty (Ambulatory, Case Management, ED and Inpatient)
4. Geographic Factors

The State has provided each managed care plan with a HH eligible list of patients sorted from highest to lowest predictive risk. The State is working on the development of Patient Rosters for each county in the wave one rollout that take the factors above into priority consideration for initial health home assignment. The goal is to assign and outreach to the highest risk (based on a predictive model) and highest cost members with the lowest primary and ambulatory care connectivity in each health home area. Once those members have been assigned and enrolled then the State and health plans will move down the list using provider loyalty and geography as markers for initial health home assignment. The details of this algorithm will be approved by all the State partners (DOH, OMH, AIDS Institute and OASAS) and will be recommended to health plans as one means of distributing members through intelligent assignment to each of the State approved health homes.